city**benefit**
new**directions**

Preferred Provider Organization (PPO) Plan

2005-2006
Plan Year

Great-West[SM]
HEALTHCARE

CITY OF LONG BEACH
INCORPORATED 1897

Table of Contents

Welcome

At the City of Long Beach, we take pride in offering our valued employees competitive salaries as well as a comprehensive benefits package. Included among your benefits are several quality medical plans that offer choice and flexibility. In light of rising health care costs, new plan design opportunities, and changing employee needs, the City's health care plans are reviewed and modified annually to ensure that your health care needs continue to be met at a cost that is consistent with the City's financial goals. The City's goal is to continue to provide you with quality coverage options that promote health and wellness for yourself and your family.

This summary describes important plan features for the City's Preferred Provider Organization ("PPO") Plan. While every effort has been made to accurately highlight key plan provisions, it's important to note that this summary does not contain complete plan details. The plan is governed by legal plan documents. If a question arises as to matters not addressed in this summary, or if there is any conflict between statements in this summary and the legal plan documents, the terms of the plan documents or insurance contracts shall govern. Please note that nothing in this booklet says or implies that participation in the plan is a guarantee of continued employment with the City.

Your health care benefits are a valuable part of your total compensation. To make the most of them, read this booklet to learn how your plan works. From time to time, the City may give you other written materials on your plan. Be sure to keep these materials with this booklet so that your plan information remains current and in one place.

Eligibility & Effective Dates

Eligibility

Eligible Employees

You are eligible to participate if you reside in the United States and are a regular, full-time employee scheduled to work an average of 40 hours per week, or you are a retired employee who is not eligible for Medicare.

Eligible Dependents

Your eligible dependents include:

- Your legal spouse.
- Same sex domestic partner (active employees only).
- Your unmarried dependent children from birth to age 19. This includes natural children, stepchildren, and adopted children. Foster children, when there are court orders for legal custody and they are placed in a Certified Foster Home, are also included.
- Your unmarried, dependent child up to age 26 if a full-time student at a state recognized educational institution.
- Your unmarried, dependent child who is totally incapacitated due to mental retardation or physical handicap before reaching the age at which coverage would otherwise end. Eligibility for the child will be extended for as long as you are covered by the plan, the disability continues, and the child continues to qualify for coverage in all respects other than age. You will be required within 6 months prior to the date that coverage would otherwise terminate to submit a current physician's statement certifying the disability. If this proof is not submitted within 60 days of the request, the child's coverage under this policy will terminate. You may be required to submit additional statements from time to time which certifies the continuing disability.

Dependent children must rely on an employee for at least 50% of their principal support and be eligible to be claimed on the employee's annual federal tax return.

Effective Dates

When Coverage Begins

- If you are hired on the 1st through the 4th of the month, you will become eligible on the first day of the following month. If you are hired on the 5th of the month or later, you will become eligible on the first day of the month following one month of continuous, full-time work.
- If you enroll during the annual open enrollment period, coverage begins the following December 1 for active employees or February 1 for retirees.
- Coverage for your eligible dependents begins when your coverage begins, provided you enroll your dependent within 31 days of the date you were first eligible to do so.
- Coverage for new dependents begins from the date they first become eligible (newborns are covered from birth) provided you enroll your dependent within 31 days of their eligibility.

Note: Once your dependent is enrolled, you have three months to provide satisfactory proof of dependent eligibility, otherwise that dependent will automatically become ineligible.

When Coverage Ends

Participation in the Plan ends when the earlier of the following occurs:

- The last day of the month in which you leave your job
- You change to an ineligible status
- Your death
- A dependent no longer meets the eligibility requirements, with respect to that dependent's coverage
- The last day of a period for which you fail to make any required contributions for coverage
- The day the Plan ends

In certain situations, you may be eligible to continue certain plan coverage for a period of time. Please refer to the "Continuation of Coverage" section for details.

Key Terms

To make the most of your coverage, it is important that you understand the following terms. For ease of reference, these terms are listed alphbetically.

Ambulatory Surgical Center

A public or private institution that is:

- Established, equipped and operated primarily as a facility for performance of surgical procedures and meets the following requirements:

  (a) is operated under the supervision of a staff of doctors, maintains adequate medical records and provides for periodic review of the facility and its operation by a Utilization and/or Tissue Committee composed of doctors other than those owning or supervising the facility;

  (b) permits a surgical procedure to be performed only by a doctor privileged to perform such a procedure in a hospital in its area and requires that a licensed anesthesiologist administer the anesthetics and be present during the surgical procedure, unless only local infiltration anesthetics are used;

  (c) provides no overnight accommodations for patients, has at least two operating rooms, one post-anesthesia recovery room and full-time services of registered nurses (RN) in all operating and post-anesthesia recovery rooms;

  (d) is equipped to perform diagnostic x-ray and laboratory examinations and has the necessary equipment and trained personnel to handle foreseeable emergencies, including a defibrillator for cardiac arrest, a tracheotomy set for airway obstruction, and a blood bank or other supply for hemorrhaging;

  (e) maintains written agreements with hospitals in its area for immediate acceptance of patients who develop complications or require postoperative confinement; or

- Licensed as an ambulatory surgical center by the state in which the center is located.

Attention Deficit Disorder (ADD)

The American Psychiatric Association describes ADD as a disease of infancy and childhood characterized by developmentally inappropriate inattention, impulsivity, and hyperactivity.

Brand Non-Preferred Prescription Drug

Brand Non-Preferred Prescription Drugs are made by the original manufacturer of the drug; they do not appear on the plan's formulary.

Brand Preferred Prescription Drug

A Brand Preferred Prescription Drug is a product made by the original manufacturer of the drug that is listed on the plan's formulary. When a physician requests that a prescription be "filled with the brand preferred," it means that the request is for the product made by the original manufacturer.

Copayment

Copayment is the amount you are required to pay when you receive certain covered services, such as office visits and exams from network providers.

Covered Benefit

Eligible expenses will be covered as follows: Eligible network expenses will be based on the contracted rate with the particular network provider for the specific services rendered as of the date those services are rendered. Any remaining network plan deductible and network coinsurance provisions will be applied to this amount to determine the network Covered Benefit. Eligible non-network expenses will be determined based on the usual, customary, and reasonable charges for the specific services rendered by a non-network provider at the date of service and within the geographic area where services are rendered. Any remaining non-network plan deductible and non-network coinsurance provisions will be applied to this amount to determine the non-network Covered Benefit.

Custodial Care

Custodial care consists of charges made in a nursing home for non-medically necessary services and are not covered by the plan. Custodial care means the kind of care which helps a person meet the activities of daily living. Custodial Care includes but is not limited to:

- Help in walking
- Help in getting in and out of bed
- Help in bathing, dressing, feeding and using the toilet
- Preparation of special diets
- Housekeeping
- Supervision of medication which:
  - does not need the continuing attention of trained medical or paramedical personnel; and
  - can usually be administered by:
    - the person himself; or
    - a member of his family; or
    - any other person who has not had formal medical training

Deductible

The plan year deductible is the amount of covered expenses you pay each year before the plan begins to make payments.

Generic Name

A Generic Name is the official drug name, as determined by the United States Adopted Names (USAN) and accepted by the Federal Drug Administration (FDA), for that drug regardless of its manufacturer. Each drug has only one generic name.

Generic Prescription Drug

A Generic Prescription Drug refers to the product manufactured by a drug company other than the original manufacturer of the drug, meeting all FDA bioavailability standards. California law allows pharmacists filling a prescription order for a drug product prescribed by a brand name to select a product of the same generic drug type unless the prescriber personally indicates "do not substitute," or if the member specifically requests a brand name product. This is the process known as "filled with the generic."

Hospital

A hospital is a:

- Legally operated institution providing inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under supervision of a staff of doctors, and with 24-hour-a-day nursing services;
- Medical facility accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- Christian Science Sanatorium or other institution approved by the Department of Care of the Mother Church, The First Church of Christ, Scientist in Boston, Massachusetts.

The term "Hospital" does not include a nursing home, nor an institution or part of one which (a) is used mainly as a facility for convalescence, nursing, rest, or the aged, (b) furnishes primarily domiciliary or custodial care, including training in daily living routines.

Medically Necessary

A service or supply is medically necessary when it is appropriate and required, and is generally accepted in medical practice as necessary for the diagnosis or treatment of accidental injury, sickness or pregnancy.

MES

Medical Eye Services.

MES Participating Providers

A group of Ophthalmologists and Dispensing Opticians who have agreed to participate in the City's vision care plan. You may obtain a provider list from your Departmental Payroll/Personnel Assistant.

Non-compliance Fee

A $500 fee that you are required to pay if the insurance carrier is not contacted and/or recommendations are not followed.

Non-Network Provider

A physician or facility that does not participate in the plan's network.

Nurse

A registered graduate nurse. Such term also includes a Christian Science Nurse authorized by the Mother Church, The First Church of Christ, Scientist in Boston, Massachusetts.

Services furnished in California by a clinical social worker will be eligible under the plan to the extent they would have been eligible if furnished by a doctor licensed by California as a physician and surgeon, provided the services are performed upon referral by such a doctor and the social worker is licensed by California and authorized by law to perform the services.

Outpatient Psychiatric and Substance Abuse

Covered expenses for Outpatient Psychiatric and Substance Abuse means those charges by a physician, psychologist, licensed Clinical Social Worker, or psychiatrist for:

- Outpatient treatment of Attention Deficit Disorder
- Outpatient treatment of alcoholism
- Outpatient treatment of drug addition
- Outpatient services for psychotherapy

Outpatient Surgery

- Facility charges for the Hospital Outpatient Department, Ambulatory Surgical Center or Doctor's Surgical Suite.
- Surgeon's charges.
- Assistant Surgeon's charges. The covered expense limit for assistant surgeon's charges shall be 20% of the amount charged by the primary surgeon.
- Anesthesia.
- Required pre-surgical tests performed within 7 days before surgery performed at a Surgical Center or Outpatient Department of a hospital. This includes, but is not limited to, blood tests, urinalysis and x-rays.
- Pathology and Radiology expenses incurred in relation to surgery and performed within 7 days after surgery.

Paid Benefit

The maximum amount the insurance carrier will pay for eligible expenses that are:

- The lesser of reasonable and necessary or
- Otherwise contracted for with a network PPO provider.

Physician

A licensed practitioner of the healing arts acting within the scope of his license. Such term also includes the personal services of a Christian Science Practitioner authorized by the Mother Church, The First Church of Christ, Scientist in Boston, Massachusetts.

Plan Maximum

Plan maximum is the maximum dollar amount that the plan will pay, where applicable.

PPO Network Hospital

A facility that has been selected by the insurance carrier and that participates in the plan's national network. A listing of network hospitals may be viewed online at www.mygreatwest.com. To find out if your hospital participates in the network, you may also call the Great-West Healthcare Benefit Payment Office at (800) 766-3206.

PPO Physician or Network Provider

A physician selected by the insurance carrier and who participates in the plan's national network. These providers have been precertified and credentialed, and have agreed to take discounted fees for their services. A listing of network providers may be viewed online at www.mygreatwest.com. To find out if your physician participates in the network, you may also call the Great-West Healthcare Benefit Payment Office at (800) 766-3206.

Pre-admission Testing

Diagnostic x-ray and laboratory tests performed in a clinic or in the outpatient department of a hospital for a condition for which an inpatient stay has been scheduled. These tests must meet all the requirements listed below:

- Performed in place of tests that would normally have been performed during the scheduled inpatient confinement and are accepted as such by the hospital concerned.
- Prescribed by the doctor who scheduled the inpatient confinement or the doctor who attends the patient during the scheduled inpatient confinement.
- Performed in the 7 days prior to the scheduled inpatient confinement.

Precertification

A review process designed to confirm the effectiveness of proposed medical treatment. With precertification, inpatient hospital confinements and outpatient surgeries (except those performed in a physician's office) are evaluated against other non-surgical treatments and prior treatment history of the patient. When you use a PPO provider, your doctor is responsible for obtaining precertification. ***If you are hospitalized or have surgery through non-network providers, it is important that you and/or your medical provider call (800) 766-3206 for precertification before your treatment, if possible, or within 48 hours following treatment.***

Reasonable Charge

Charges for services provided by a network physician or in a network hospital are considered to be reasonable as long as they do not exceed the limits negotiated with the insurance carrier. **With the exception of the deductible and copayment, network providers have agreed to accept payment from the Plan as payment in full and cannot bill you for any additional amount (over your deductible or copay).** Charges for all other services are considered reasonable if the insurance carrier determines they are comparable to the usual cost for appropriate treatment, services or supplies for similar medical conditions in your geographic area, based upon data reviewed by the insurance carrier. If non-network expenses are more than the reasonable charge, you pay this difference.

Second Opinion

A professional opinion regarding any surgery recommended by a physician, provided by another physician who:

- Is a Board Certified Surgeon or specialist;
- Is not financially associated with the physician who first recommended the surgery; and
- Will not perform the surgery.

Covered expenses will include charges incurred for diagnostic x-ray and laboratory procedures which are required to formulate a "Second Opinion." *Charges for duplicate diagnostic testing will not be covered.*

Skilled Nursing Facility

A Skilled Nursing Facility is an institution, or distinct part of one, which meets all of the following requirements: It must have a transfer agreement with at least one hospital as defined herein and chiefly provide 24-hour skilled nursing care and rehabilitation services for the treatment of injured, disabled or sick persons. It must have policies which are developed and reviewed by a group of professionals which includes at least one physician and also must have a physician, registered nurse or medical staff who is responsible for enforcing such policies. Further, it must require that a physician supervise the health care of each patient, have a physician available at all times, keep clinical records on all patients and employ at least one registered nurse full-time. It must provide facilities for dispensing and administering drugs, be legally licensed by the state of location, have a utilization review plan, not be chiefly a place for the aged, alcoholics, drug addicts, the mentally ill or the retarded, nor be a place for custodial care.

How the Plan Works

The City's Preferred Provider Organization (PPO) Plan offers an extensive network that includes physicians, hospitals and other types of health care providers. As long as you use providers who participate in the network, your care will be covered at the highest benefit level – generally 80% after your deductible. Some services require only a copayment. There are no claim forms when you use in-network providers.

The PPO also gives you the option to access care through out-of-network providers, but services are then covered at only 60% of usual, reasonable and customary fees, higher deductibles apply, and claim forms are required.

	In-Network	Out-of-Network
Plan Year Deductible	$300 individual $600 family	$500 individual $1,000 family
Hospital Admission Deductible	$200 per admittance	$500 per admittance
Annual Maximum	Unlimited	$500,000
Covered Expense/ Out-of-Pocket Limit	Plan pays 100% after you reach $30,000 (i.e. $6,000 of out-of-pocket expenses excluding deductibles and copays) for each covered person	No limit

Plan Deductible

In-Network

The in-network plan year deductible amount is $300 per person. This amount is paid only once if two or more family members incur expenses as a result of the same action. The maximum deductible amount is $600 per family for each plan year. Expenses applied against the deductible levels in the last three months of a benefit year may also be applied to the deductible for the following plan year.

Out-of-Network

The out-of-network plan year deductible amount is $500 per person. This amount is paid only once if two or more family members incur expenses as a result of the same action. The maximum deductible amount is $1,000 per family for each plan year. Expenses applied against the deductible levels in the last three months of a benefit year may also be applied to the deductible for the following plan year.

Hospital Admission Deductible

In-Network

You pay a $200 deductible each time you are admitted to a network hospital.

Out-of-Network

You pay a $500 deductible each time you are admitted to an out-of-network hospital.

Precertification

In-Network

When you use a PPO provider, your doctor is responsible for obtaining precertification. Be sure that your doctor takes the necessary steps to inform the insurance carrier of impending hospitalization or surgery.

Out-of-Network

If you are hospitalized or have surgery out-of-network, it is important that you and/or your medical provider call (800) 766-3206 for preauthorization before your treatment, if possible, or within 48 hours following treatment.

Covered Expenses

In-Network

After you have satisfied the deductible and copayments, the plan pays 80% of remaining covered expenses, except where otherwise described in this booklet, in any one plan year. The plan will pay reasonable and necessary charges at the percentages listed only until the amount of such covered network expenses reaches $30,000 per person. Once the $30,000 per person Break Point has been reached, covered network expenses will be payable at 100% for the rest of the plan year. Once two family members have each reached the $30,000 Break Point, all additional covered network charges will be covered at 100% for the remainder of the plan year.

All covered expenses which are paid at 100% with or without a copayment are not applied towards the $30,000 per person Break Point or the out-of-network lifetime maximum.

Out-of-Network

Eligible expenses will be reimbursed up to the reasonable and necessary charge for the services provided in the area where the expenses are incurred. Eligible expenses are those charges incurred for the services and supplies listed in this booklet for the treatment of injuries and sickness, and will be covered at 60% after deductible unless otherwise specified.

Precertification

General Provisions

When you need to be hospitalized or require surgery, you must obtain precertification through the insurance carrier (Great-West Healthcare), which assures that recommended treatment is both appropriate and cost effective. Precertification helps protect you from receiving outdated or unnecessary treatment or surgery. And, it minimizes the time you have to spend in the hospital, which helps lower your expenses. In addition, this service will inform your doctor of any cost-saving features that your plan may have, such as special coverage for home health care or incentives for using outpatient facilities.

The insurance carrier will review each proposed hospital admission and each proposed surgical procedure which is to be performed outside the doctor's office (excluding minor first aid), and will then determine and authorize:

- The medical necessity of such treatment,
- The appropriate location for such treatment (inpatient vs. outpatient) to be provided, and
- In the case of a hospital admission, the length of stay for each inpatient hospital confinement.

PPO network providers will obtain precertification for you. ***If you do not receive care from a network provider, it is your responsibility to make sure your treatment is precertified.*** Simply call the toll-free Member Services number, (800) 766-3206. You will be responsible for a $500 non-compliance fee if you do not precertify.

Precertification must be initiated 10 days prior to an elective admission date or in the case of an emergency, within 48 hours of the date the emergency treatment begins.

Some surgeries and/or procedures require more in-depth review of specific medical criteria. Currently, if one of the following procedures is precertified by your physician, you may receive a follow-up phone call from a medical professional who will talk with you further about your proposed treatment. A letter confirming the precertification will follow.

- Cardiac Cath
- Carpal Tunnel Release
- Coronary Artery Bypass Graft (CABG)
- Hemorrhoidectomy
- Hysterectomy
- Knee Arthroscopy
- Lumbar Laminectomy
- Magnetic Resonance Imaging (MRI)
- Mohs Chemosurgery
- Septo-Rhinoplasty
- Tonsillectomy
- Upper Gastro Intestinal (UGI) Endoscopy

If you receive emergency treatment, you must contact your physician within 48 hours to allow the precertification process to take place. If you or your physician do not follow this procedure, you will be responsible for a $500 non-compliance fee.

If the insurance carrier is contacted as above, but you do not follow the authorization, or the insurance carrier is not contacted as described above then:

- The claim may be reviewed by the insurance carrier to determine which expenses, if any, are eligible for payment under this plan, and
- Expenses related to a hospital admission or outpatient surgery (excluding minor first aid) will be subject to the $500 non-compliance fee.

The $500 non-compliance fee is in addition to any other deductible under this plan and will not be used to satisfy any Break Point.

The $500 non-compliance fee will be waived for services received at a Network Hospital and rendered by a Network Physician. However, your physician will be responsible for contacting the insurance carrier to determine medical necessity and length of stay. Please note that you should receive a written notice from the insurance carrier within 7 days confirming your precertification. Contact your physician if you do not receive your written confirmation.

Second Opinions

The insurance carrier may require a second opinion before granting prior authorization for expenses incurred for certain treatment. In this case, these expenses will not be subject to any deductible under this plan and will be payable at 100%, but only if required by the insurance carrier.

All other eligible charges for second opinions not required by the insurance carrier will be paid at the network or the out-of-network benefit level, whichever is appropriate. All deductibles and copayments will apply.

Maternity Patient Special Requirement

It is your responsibility to ensure your physician's office contacts the insurance carrier 60 days prior to the scheduled delivery date.

PPO Summary of Benefits

Hospital Expenses

In-Network	Out-of-Network
After the plan year deductible, and the $200 per hospital confinement deductible, the plan pays 80% of remaining covered expenses in any one plan year for the services listed below unless otherwise specified.	After the plan year deductible and the $500 per hospital confinement deductible, the plan pays 60% of reasonable and necessary charges in any one plan year for services listed below unless otherwise specified. Covered expenses are payable up to an Annual Maximum of $500,000

Room and Board Charges

The plan pays a percentage of room and board charges for semi-private care. The eligible expenses are subject to the plan year deductible in addition to the applicable hospital admission deductible. Special limits apply for out-of-network expenses.

Charges for personal items such as the use of telephone and television are not considered eligible expenses.

In-Network	Out-of-Network
Plan pays 80% after plan year deductible and after hospital admission deductible of $200 per confinement	Plan pays 60% after plan year deductible and after hospital admission deductible of $500 per confinement, up to a $300 covered maximum per day ($300 x 60% = $180 paid maximum per day). Charges for intensive care and/or specialized units will not exceed a $900 covered maximum per day ($900 x 60% = $540 paid maximum per day).

Services and Supplies

After deductible, the plan pays a percentage of services and supplies furnished by the hospital for medical care associated with a hospital confinement such as operating room, x-rays, laboratory tests, medicines, nursing care, therapy, etc.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Surgery

After deductible, the plan pays a percentage of the facility charges associated with surgery performed in a hospital or in an ambulatory surgical center.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Nursery Expenses

After deductible, the plan pays a percentage of the routine nursery charges for a well newborn infant up to the first 7 days of life. Please remember to enroll your baby at the time of birth.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Physical and Occupational Therapy

After deductible, the plan pays a percentage of covered expenses for physical and occupational therapy when rendered on an inpatient or outpatient basis by a licensed therapist.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Mental, Psychoneurotic & Personality Disorders and Substance Abuse

After a copay per confinement, the plan pays a percentage of room and board charges incurred for inpatient treatment of mental, psychoneurotic and personality disorders. A $300 maximum per day ($180 paid maximum) applies for out-of-network services. In-network and out-of-network expenses are subject to a plan year benefit maximum of $15,000 and a combined in- and outpatient lifetime maximum benefit of $50,000. The eligible expenses are subject to the plan year deductible.

In-Network	Out-of-Network
After a $200 copay per confinement, the plan pays 80%	After a $500 copay per confinement, the plan pays 60% up to a $300 maximum per day ($180 paid maximum)

Inpatient Physician Expenses

In-Network	Out-of-Network
After the plan year deductible, the plan pays 80% of remaining covered expenses in any one plan year for the services listed below unless otherwise specified.	After the plan year deductible, the plan pays 60% of reasonable and necessary charges in any one plan year for services listed below unless otherwise specified.

Physician Fee

After deductible, the plan pays a percentage of the charges for the physician's fee for services rendered in connection with a covered illness or surgical procedure.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Surgical Expenses

After deductible, the plan pays a percentage of a doctor's fee for a covered surgical procedure and for anesthesia services rendered in connection with the performance of a covered surgical procedure. Expenses incurred for the services of an assistant surgeon will also be considered a covered expense, if medically necessary, but shall not exceed 20% of the primary surgeon's fee. *Please note that assistant surgeon's bills will not be paid until receipt of the surgeon's bills.*

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Anesthesia Expenses

After deductible, the plan pays a percentage of the charges for anesthesia services rendered in connection with the performance of a covered surgical procedure.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Anesthetics and Their Administration

After deductible, the plan pays a percentage of the charges related to pain management administered by an anesthesiologist.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Outpatient Physician Expenses

In-Network	Out-of-Network
After the plan year deductible, the plan pays 80% of remaining covered expenses in any one plan year for the services listed below unless otherwise specified.	After the plan year deductible, the plan pays 60% of reasonable and necessary charges in any one plan year for services listed below unless otherwise specified.

Office Visits

The plan pays a percentage of covered expenses after you pay a copayment per visit for medically necessary services by family practice, OB/GYN, internist, and/or specialist.

In-Network	Out-of-Network
Plan pays 100% after a $25 Copay	Plan pays 60%

Pre-natal Office Visits

After deductible, the plan pays a percentage of covered expenses for normal, pre-natal treatment during pregnancy.

In-Network	Out-of-Network
After deductible, the plan pays 100% after a $25 copayment for the first visit only; thereafter, the plan pays 80%	After deductible, the plan pays 60%

Routine Physical Examinations

Generally, the plan pays a percentage of covered expenses for routine physical examinations up to a $250 maximum for each covered individual over one year of age in any one plan year. Covered expenses include:

- Examination of heart, lungs and abdomen, and associated diagnostic services
- Gynecological exams and services which include:
  - One routine exam, including a pelvic exam per year
  - One Pap Smear per year
  - For a woman age 35 or older, one routine mammogram per year
- Routine lab services, including pap smears
- For children who are one year of age or older, necessary immunizations and booster shots

In-Network	Out-of-Network
Plan pays 100% after a $25 copayment per visit, up to a maximum of $250 for each covered individual per plan year	After deductible, the plan pays 60%, up to a maximum of $250 for each covered individual per plan year

Well Baby Care

The plan pays a percentage of covered expenses for children under one year of age up to a $250 maximum per child per plan year. Covered expenses include:

- Weight and measurement
- Hemoglobin counts and urinalysis
- Necessary inoculations (excluding cost of materials)
- Instructions to parents regarding health care
- Circumcision

In-Network	Out-of-Network
Plan pays 100% after a $25 copayment per visit, up to a maximum of $250 for each covered child per plan year	After deductible, the plan pays 60%, up to a maximum of $250 for each covered child per plan year

Outpatient Surgery

After deductible, the plan pays a percentage of the medical charges associated with outpatient surgery performed in the outpatient department of a hospital, an ambulatory surgical center, or in the doctor's office.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

X-ray and Lab Treatment

After deductible, the plan pays a percentage of covered expenses for outpatient diagnostic and x-rays and laboratory tests when recommended by a PPO Physician.

In-Network	Out-of-Network
Plan pays 80%	Plan pays 60%

Outpatient Psychiatric and Substance Abuse

The plan pays a percentage of covered expenses up to a $75 per visit covered maximum ($45 paid maximum) for expenses incurred for psychotherapy rendered by a physician, psychologist, licensed Clinical Social Worker, or psychiatrist. Charges that exceed $75 will require additional out-of-pocket expenses. The maximum the plan will pay in any one plan year is $1,500 (combined for in-network and out-of-network). This includes charges incurred for the treatment of Attention Deficit Disorder.

In-Network	Out-of-Network
Plan pays 100% of a $75 per visit maximum after you pay a $25 copayment per visit, up to $1,500 per year	After deductible, the plan pays 60% of a $75 per visit maximum, up to $1,500 per year

Other Covered Services

In-Network	Out-of-Network
After the plan year deductible, the plan pays 80% of remaining covered expenses in any one plan year for the services listed below unless otherwise specified.	After the plan year deductible, the plan pays 60% of remaining covered expenses in any one plan year for services listed below unless otherwise specified.

Please note that services are listed in alphabetical order.

Acupuncture Services

For both in-network and out-of-network services, the plan pays only 50% of covered expenses after the plan year deductible, up to $60 per visit covered maximum. Payment for each office visit will not exceed $30. Payment for each plan year will not exceed $1,000 for all acupuncture services

Allergy Treatment

The plan pays usual and customary treatment when medically necessary. You only pay a copayment for an office visit when treated by an in-network physician.

Ambulance Service

The plan pays expenses when medically necessary, including life-threatening emergency transportation by an airline or air ambulance to the nearest hospital equipped to provide required treatment.

Attention Deficit Disorder (ADD)

ADD is described by the American Psychiatric Association as a disease of infancy and childhood characterized by developmentally inappropriate inattention, impulsivity, and hyperactivity. The plan pays expenses incurred for this treatment as outpatient psychiatric services. Benefits will be subject to the Outpatient Psychiatric and Substance Abuse copayment and plan year benefit maximum.

Chiropractic Services (Spinal Adjustment Treatment)

In-Network

When you use an American Specialty Health Plans (ASHP) provider, the plan pays 100% of the contracted rate up to a maximum of $30 per visit. Eligible expenses are subject to the plan year deductible. You pay no copayment. The plan year paid maximum is $1,000 for all spinal adjustment/ treatment. ***Benefits are offered on a self-referral basis.*** For an ASHP chiropractor in your area, see your directory or call (800) 678-9133. Contracted providers have agreed to accept reduced fees for services which means you pay fewer dollars for health care services than you would using non-contracted providers.

Out-of-Network

When you use a non-network chiropractor, the plan pays 50% of covered expenses up to $60 per visit, not to exceed $30 paid per visit, after the plan year deductible is met, up to a maximum of $1,000 per plan year.

Chronic Headache and Pain Control

The plan pays medically necessary treatment expenses for patients who suffer from chronic pain that has not been resolved after traditional treatments have been explored. Treatment rendered in a Headache Pain Control Clinic will be considered a covered expense under the plan if such clinic is a part of hospital facility and is staffed by physicians and licensed physical therapists. Biofeedback and psychiatric counseling, as part of the course of treatment, will be covered as outpatient psychotherapy under the plan and will be subject to the copayment and plan year benefit maximum. During the course of such treatment, the plan will not pay for expenses such as thermagrams, hotel expenses, transportation and family therapy.

Dental Expenses

The plan pays for treatment received by a dentist, physician or oral surgeon for a diagnosed illness, fractured jaw, or injuries to natural teeth, including replacement of such teeth and related x-rays, when treatment is necessary as the result of an accident and services are rendered within 12 months after the accident. *Injury as a result of normal biting and chewing is not considered an accidental injury.*

Doctor's Services

In addition to regular office visits, the plan pays benefits for home treatment and other medical care and treatment.

Durable Medical Equipment

The plan pays 80% covered expenses if you rent or purchase Durable Medical Equipment (DME) from a PPO contracted facility, or 60% if you rent or purchase DME equipment from a non-network provider. Please call (800) 766-3206 to find the contracted facility closest to you. Listed on the following page are the most common purchases of durable medical equipment. Please contact the Great-West Healthcare Benefit Payment Office at (800) 766-3206, to ensure that the equipment you are renting or purchasing will be a covered expense after the deductible.

- Apnea Monitor
- Asthma Peak Flow Meter
- Bilirubin Light
- Blood Glucose Monitor
- Breast Prosthesis
- Braces
- Colostomy Supplies
- Commodes
- Crutches
- Diabetic Supplies
- Hospital Beds
- Insulin Supplies
- Walkers
- Wheelchairs

Emergency Treatment

The plan pays care and treatment expenses incurred in the emergency room of a hospital, urgent care or other facility. For care and treatment received in a physician's office, you pay the doctor visit copayment (see "Outpatient Physician Expenses" section). Conditions deemed to be life threatening emergencies will be paid at the network level of benefits.

Hearing Aids

The plan pays covered benefits which include services of an audiologist, an initial hearing aid or set of hearing aids, repairs, examinations and testing for the fitting of hearing aids and ear molds in any three year period. The benefit maximum will not exceed $1,000 during any three-year period (36 consecutive months). Contracted providers have agreed to accept reduced fees for their services which means you pay fewer dollars for health care services than you would using non-contracted providers.

Home Health Care

See page 17 for details.

Hospice Care

See page 18 for details.

Medical Supplies

The plan pays for drugs and medicines by a licensed pharmacist, blood plasma not replaced by or for the patient, artificial limbs, eyes and larynx, electronic heart pacemaker, surgical dressings, casts, splints, trusses, braces, crutches, rental of wheel chair, hospital bed, or iron lung, oxygen and rental of equipment for its administration. This also includes some durable medical supplies directly associated with the treatment of a covered sickness, injury or surgery. Please contact the Great-West Healthcare Benefit Payment Office at (800) 766-3206 for the specific supplies which are covered.

Newborn Care

The plan pays routine nursery care for up to the first seven days of life. Please remember to enroll your baby at the time of birth.

Nursing Care

The plan pays for medically necessary care rendered by a registered nurse as part of Home Health Care benefits.

Occupational Therapy

The plan pays covered expenses for occupational therapy when rendered by a licensed occupational therapist.

Orthotics

The plan pays expenses if they are prescribed by a physician or podiatrist, custom designed for the particular patient, considered effective treatment for the condition and required for all normal activity. The plan will pay up to $75 every three years (36 consecutive months). Contracted providers have agreed to accept reduced fees for their services which means you pay fewer dollars for health care services than you would using non-contracted providers.

Physical Therapy

The plan pays covered expenses for physical therapy when rendered by a licensed physiotherapist.

Podiatry (treatment of feet)

The plan pays covered expenses which include usual and customary treatment for surgical procedures which involve the exposure of bones, tendons or ligaments: removal of nail and nail matrix; and treatment rendered for metabolic or peripheral vascular disease. Non-surgical treatment of toenails, treatment of superficial lesions of the feet (such as corns and calluses) and non-surgical treatment of weak, strained, unstable, flat feet or bunions are not covered. (See Orthotic benefit above.)

Pregnancy (OB/GYN) Benefits

See page 20 for details.

Skilled Nursing Facility

See page 17 for details.

Speech and Hearing Therapy

The plan pays up to a lifetime maximum of $5,000 for all expenses incurred in connection with such services, provided the therapist holds a Certificate of Competence from the American Speech and Hearing Association. Benefits are payable for correction of a speech impediment incurred while covered if caused by sickness, injury or surgery on account of illness. A speech impediment due to a congenital abnormality is included only after corrective surgery is performed. A speech impediment due to cerebral palsy will be covered without corrective surgery. Expenses for services of a speech therapist due to a functional nervous disorder are not covered.

TMJ (Temporomandibular Joint Dysfunction Syndrome)

TMJ is the name given for the condition that results from injury or disease of the hinge joint which controls the lower jaw. The plan pays covered medical expenses which include exams and diagnostic x-rays, muscle and nerve block injections, and manipulation under anesthesia. The plan will not pay for any treatment that is considered a dental expense such as bridgework, splints, appliances, braces, wires, or night guards.

Treatment of Obesity

The initial diagnostic office visit and DXL testing and one nutritional counseling session at the outpatient department of a hospital will be covered if ordered and approved by your physician. Eating disorders will be covered under the outpatient or inpatient psychiatric benefits of the plan.

X-ray and Laboratory Services

The plan pays for services which include x-rays, MRIs, CT scans, sonograms, ultrasounds, and other related medically necessary services.

X-ray and Radiation Therapy and Chemotherapy with Radioactive Substances

How to File Claims

In-Network

No claim forms are required when you use a Great-West PPO Hospital or Physician. Present your Great-West PPO ID card and your copayment at the time of service. Great-West Healthcare will not pay claims filed later than 15 months after the date of service. For more information, refer to the "Explanation of Benefits" section of this booklet.

Out-of-Network

Obtain a white claim form from a City of Long Beach Departmental Payroll/Personnel Assistant. Have the hospital admitting clerk or the doctor complete the form and attach their billing. The hospital, the doctor or you may forward the claim directly to the Great-West Healthcare Benefit Payment Office shown on the claim form. Great-West Healthcare will not pay claims filed later than 15 months after the date of service. For more information, refer to the "Explanation of Benefits" section of this booklet. *Retired employees should obtain claim forms from the City of Long Beach Department of Human Resources.*

If You Have Questions

For questions, call Great-West Healthcare Member Services at (800) 766-3206 (the number listed on your ID card). The Member Services Team will assist you with all of your questions regarding claims, physician, hospital or specialist selection and other special assistance.

Prescription Drug Benefits

Overview

Prescription drug coverage is offered through Express Scripts, a nationwide network of more than 50,000 pharmacies linked to an electronic claims system. All participating pharmacies have agreed to limit their charges to Express Scripts cardholders, which usually means lower out-of-pocket costs to you. Because these pharmacies have access to your coverage information, they know exactly how much you should pay for each prescription. Claims are processed electronically at the time of purchase, so there is no need for you to complete claim forms.

The Express Scripts program includes a formulary, which is a list of drugs that the plan covers. You may still receive benefits for prescription drugs that do not appear on the formulary, but your costs will be higher.

How the Program Works

To use this program:

- Present your ID card when purchasing drugs at any participating pharmacy
- Sign the claims voucher requested by the pharmacy
- Pay the pharmacy a copay of $10 for generic drugs; $25 for brand preferred; and $40 or 30% (whichever is higher) for brand non-preferred for each prescription or refill.

If You Don't Have Your Card with You

If you don't have your healthcare ID card with you when you use a participating pharmacy, the pharmacist may be able to verify your coverage by calling the Great-West Healthcare Benefit Payment Office at (800) 766-3206. If this is not possible, you must pay the full price for the prescription and file a claim to be reimbursed. If you choose an Express Scripts pharmacy, your reimbursement will be the same amount as if you had presented your card. Express Scripts will send this reimbursement directly to you.

If You Purchase a Prescription at a Non-Express Scripts Pharmacy

If you purchase drugs at a non-participating pharmacy, you must:

- Pay the full price of the prescription and file a claim for reimbursement.
- Ask your Departmental Payroll/Personnel Assistant for an Express Scripts prescription drug claim form.

- Complete the claim form, attach your prescription drug receipt, and mail these items to the address printed on the form.

Express Scripts will send the reimbursement directly to you. You will be reimbursed for the amount which would have been paid for the prescription drug had you used a participating pharmacy. If your pharmacy charges more for a prescription drug than an Express Scripts pharmacy, you will be responsible for the difference.

Covered Expenses

All prescriptions will be covered at 100% after a copayment requirement. Generic prescriptions will require a $10 copayment and brand preferred prescriptions determined medically necessary will require a $25 copayment. Brand non-preferred prescriptions will require a copay of $40 or 30% of the actual cost, whichever is higher. All prescriptions determined medically necessary by your physician will be filled for up to or part of a 30 DAY SUPPLY.

A brand name prescription REQUESTED when a generic is available or NOT determined medically necessary by your physician will require additional copayments. **If you request a brand-name drug when there is a generic equivalent, you must either purchase the generic drug, or pay 100% of the difference between the brand-name price and the generic price, plus the copayment. The only exception to this rule is if your doctor writes "Dispense As Written," or "DAW," on your prescription, in which case the brand-name drug will be dispensed at the brand-preferred or brand non-preferred copayment (depending on the drug).**

Over the counter prescriptions (drugs which do not require a prescription to be purchased) such as vitamins or fluoride, are not considered to be eligible under the plan. Diet pills, including Meridia and Xenical are not covered even when they are prescribed by your PCP or a diet center.

Oral contraceptive prescription drugs are covered by the plan. Impotence dysfunctional drugs (such as Viagra) will be covered up to 10 pills per month (after you meet your deductible) when these steps are followed:

1. You must be examined by a urologist who determines the medical necessity of the drug.
2. The first and second prescription must be written by the urologist who will document the medical reason for the drug and after the first month will determine the effectiveness of the drug.
3. After the second prescription, your PCP may prescribe the drug, if medically necessary, for up to two years.
4. For continued use of impotence dysfunctional drugs after two years, you must go through the previous steps 1 – 3 again.

Save Money with Generics

A generic drug is the chemical equivalent of a brand-name prescription drug. Generic drugs can cost up to 95% less than their brand-name counterparts, and that is their only significant difference. Generic and brand-name drugs are the same in that they are dispensed in the same dosage; taken in the same way; and packaged in the same unit strength. Generic prescriptions require only a $10 copayment, which is significantly less that the $25 copayment required for medically necessary brand preferred prescriptions.

Advantages of Mail Order

If you take maintenance medications for conditions such as high blood pressure, diabetes or asthma, you can save money by purchasing your prescriptions by Express Scripts Mail Order. When you purchase prescriptions through the mail, you pay twice the applicable copayment for three-times the supply (90 days rather than 30 days). You also get the convenience of home delivery.

You must ask your doctor in order to participate in the Mail Order program. Your doctor should write your maintenance medication prescription for up to a 90-day supply, with up to three refills. You can order refills by telephone or over the Internet. If you are not sure whether or not your prescription is available for Mail Order, or if you would like to find out if a generic equivalent is available, you may call Express Scripts at 1-888-377-9378, or visit their website at www.express-scripts.com.

Coordination

If you are covered under another group benefit program, in order to ensure that coordination occurs, have your pharmacist give you a receipt for your prescription indicating the charge amount and the copay amount. Submit this receipt to the insurance carrier as you would any other claim. This will ensure that the Prescription Drug Covered Expense will be coordinated in the same way as any other Medical Covered Expense under this plan.

100% Full Coverage Areas

The plan will pay 100% of the reasonable and necessary charges, and the plan year deductible will be waived for the following covered medical expenses:

- The first $500 of covered expenses resulting from accidental bodily injury provided such expenses are incurred within 90 days after the accident. Expenses greater than $500 will be subject to the regular plan's percentage and deductible, if applicable.
- Covered medical expenses incurred for pre-admission hospital testing within seven days prior to the hospital admission.
- Services rendered in a birthing center. Birthing services will be covered at 100% with no deductible if admission and release occur during the period of a "one-day" stay which begins after delivery.
- Home health care covered expenses.
- Hospice care covered expenses.

For details on covered expenses related to Precertification Directed Second Opinion, refer to the "Precertification" section of this booklet.

Supplemental Accident Expense Benefit

The plan will pay 100% of the first $500 of the following covered expense resulting from an accidental bodily injury provided such expenses are incurred within 90 days after the accident.

- Hospital services and supplies for medical care
- Doctor's services for surgery and other medical care
- Ambulance services
- Dental treatment received by a dentist, physician or oral surgeon for a fractured jaw or injuries to natural teeth, including replacement of such teeth and related x-rays, when treatment is necessary as the result of an accident and services are received within 12 months of accident. Injury as a result of normal biting and chewing is NOT considered an accidental injury.
- X-ray and laboratory examinations
- Services of a registered nurse other than a close relative. ("Close relative" refers to you, your spouse or a child, brother, sister or parent of you or your spouse.)
- Drugs and medicines dispensed by a licensed pharmacist
- Surgical dressing, casts, splints, trusses, braces and crutches
- Physical therapy

The plan year deductible will be waived for expenses payable under the Supplemental Accident Expense Benefit.

Any expenses incurred over $500 will be covered at the regular plan percentage after the plan year deductible has been met.

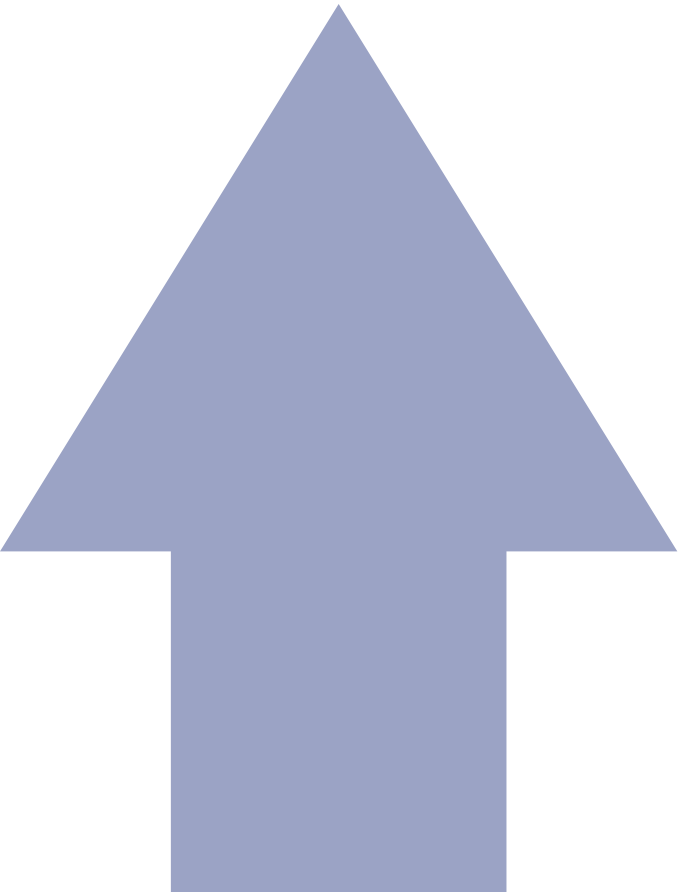
"Accidental bodily injury" means a sudden and unforeseen event which causes injury to the physical structure of the body, results from an external agent or trauma, is definite as to time and place, and happens involuntarily or, if it is the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

Please note: Claims for dental accidents should be submitted to the healthcare insurance carrier. All other claims for dental services incurred should be submitted to your dental carrier.

Skilled Nursing Facility

This part of the plan provides benefits for eligible expenses incurred during a covered skilled nursing facility (SNF) confinement after a hospital stay of at least three consecutive days that was covered by the plan. The confinement must start within 7 days after release from the hospital and be recommended by your doctor for the condition causing the hospitalization.

The eligible expenses are the SNF charges for room, board and other services and supplies furnished by the home for necessary care (other than personal items and professional services) while the patient is under continuous care of his doctor and requires 24-hour nursing care. After the plan year deductible is met, the plan pays 80% of covered charges when using network providers. When you use non-network providers, the plan pays 60% of covered charges up to $90 per day, once the plan year deductible is met. There is a 90-day plan year maximum benefit payable.



Home Health Care

The plan pays 100% of the reasonable and necessary charges made by in-network Home Health Care Agency for visits to your home and the services and supplies provided in your home. The plan pays 60% after deductible when you use non-network providers.

Visits

- Registered nurse or licensed practical nurse
- Physical, occupational, respiratory or speech therapist
- Home health care aide
- Licensed midwife or licensed nurse midwife
- Licensed nutritionist or dietician

The plan will pay for only one visit per day and up to 90 visits in each plan year. Four hours of service provided by a Home Health Care Agency is considered to be one home health care visit.

Services/Supplies

The plan covers the following services and supplies when provided at home by a Home Health Agency:

- Medical supplies, including durable medical supplies directly associated with the treatment of a covered sickness, injury or surgery
- Drugs and medicines
- Laboratory services
- Special needs when they are prescribed by a physician, nutritionist or dietician

Payment for these services and supplies is limited to the amount that the plan would have paid if the covered person had been confined in a hospital as a registered bed-patient.

Conditions

No amount will be paid for Home Health Care covered expenses unless these conditions are met:

- The confinement at home is medically necessary and is not for custodial care.
- The treatment at home starts:
  - after a period of confinement in a hospital or Extended Care Facility that lasted for at least 3 days; and
  - not more than 7 days after such confinement ended.
- The treatment at home is for the same illness (or related condition) which made the confinement in the hospital or Extended Care Facility necessary.
- A physician must give a written order for home health care services. This order must be renewed every 30 days.
- The Home Health Care Agency must be certified.

Hospice Care

Overview

Hospice care is a benefit for the terminally ill (life expectancy of 6 months or less as certified by the attending physician). Rather than the patient remaining in the hospital, when the hospital setting is no longer required, it is usually beneficial for all concerned to provide the appropriate services at home. Hospice care can consist of two types of benefits: those provided in a hospice care facility or in your home. The plan will pay 100% of eligible charges (with certain limitations) and the plan year deductible is waived when you use in-network providers. When you use non-network providers, the plan will pay 60% of eligible charges (with certain limitations) after deductible. Use of this benefit is strictly voluntary on the part of the patient.

Hospice Covered Expenses

Hospice covered expenses are eligible charges incurred for services and supplies provided to a terminally ill patient, as prescribed by the attending physician. All such services and supplies must be provided by a "hospice care facility" (defined herein) in connection with a coordinated plan of home and inpatient care which treats the family and the terminally ill person as a unit, and is executed by a team of trained medical personnel, homemakers and counselors.

Eligible Expenses

- Charges by a hospice care facility for inpatient care (room and board)
- Charges for the following home health care services provided in the family's home:
  - part time nursing care
  - physical therapy
  - purchase of non-durable medical equipment
  - rental of wheel chairs and hospital-type beds
  - homemaker services
- Charges for drugs and medicines
- Charges for bereavement services (counseling sessions with the family) following the death of the patient receiving hospice care during the bereavement period, but not exceeding $300 per family.

Key Hospice Terms

Attending Physician

A physician who is responsible for the overall care of the terminally ill patient and directing the program of hospice care for each person.

Family

The employee, his/her dependents, and parents.

Hospice Benefit Period

The period beginning on the date on which the patient is certified by the attending physician as being terminally ill and ending on the earlier of:

- The date of death of such person, or
- The date which is 6 months after the date on which such person was certified as being terminal.

In the event the hospice benefit period ends prior to the date of death of the terminally ill person, a new benefit period shall begin if the attending physician certifies in writing that the person is still terminally ill.

The last hospice benefit period for a terminally ill person shall include a bereavement period which begins on the date of death of such person and ends three months after it begins.

Hospice Care Facility

A facility which provides:

- Inpatient hospice care,
- Home health care services,
- Bereavement services for surviving family members for terminally ill persons, provided such facility is licensed or approved in the geographical area in which the facility is located.

Terminally Ill

A life expectancy of six months or less as certified in writing by the attending physician.

Maternity Assessment Program

The Maternity Assessment Program helps mothers-to-be take an active role in identifying and avoiding pregnancy risk.

Within the first 12 weeks of your pregnancy, call the Great-West Healthcare toll-free number, (800) 766-3206, on the front of your health plan ID card. You'll reach a maternity nurse, a registered nurse specially trained in maternal and child healthcare.

Your maternity nurse will ask you a few basic questions about your family, personal medical history, habits and lifestyle. This information will be used to evaluate your chances for possible complications. Of course, all information obtained during the interview is confidential and will only be shared with those directly involved in your medical care. You'll receive educational materials which address proper diet, exercise, rest and the importance of receiving medical care during pregnancy to increase the chances of having a healthy, full-term baby. Your maternity nurse will work with you and your doctor to help provide you with the care and education necessary during your pregnancy.

Your maternity nurse will follow the progress of your pregnancy, calling you at the beginning of each trimester to make sure everything is progressing smoothly. If it's determined that your chances for a pre-term delivery or other complications are high, your nurse will follow the progress of your pregnancy more intensely and conduct more frequent risk screenings with you.

Remember, the earlier you call, the sooner you and your nurse can identify possible problems that, when found early, are easier to treat.

Pregnancy Benefits

Employees & Employees' Wives

For the purpose of this health care plan, the benefits for expenses resulting from pregnancy will be determined in the same manner as an illness.

Dependent Children

Coverage for the ***normal pregnancy of a dependent child is not covered*** under the health care plan. However, coverage for direct and indirect complications of pregnancy is provided under the plan, subject to the "Exclusions" described later in this section. The benefits for the eligible expenses due to the complications will be determined in the same manner as for any other illness.

Maternity Patient Special Requirement

It is your responsibility to ensure your physician's office contacts the insurance carrier 60 days prior to the scheduled delivery date.

Complications of Pregnancy

The term Complications of Pregnancy is defined as:

Direct Complications of Pregnancy

- Pernicious vomiting, eclampsia of pregnancy, severe ante-parturn hemorrhaging due to premature separation of the placenta for any reason, postpartum hemorrhaging requiring transfusions, missed abortion.
- RH incompatibility requiring amniotic fluid tests, analysis or intrauterine transfusion.
- Caesarean section, operation for extra-uterine pregnancy; cutting through the abdominal wall as a result of the pregnancy, but after it has terminated.
- Gestational diabetes.
- Spontaneous termination of pregnancy before there can be a viable birth. A viable birth means the fetus is capable of living outside the uterus, which is generally at 24 weeks and at least 7 ounces.

Indirect Complications of Pregnancy

- Bodily or mental disorders which are distinct from pregnancy but adversely affected or caused by it — such as acute nephritis, nephrosis, cardiac decompensation and similar conditions of comparable severity.
- Therapeutic abortion within 12 weeks of pregnancy required as treatment of a condition which is life threatening for the mother or the child.

Complications of Pregnancy does not include false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, pre-eclampsia, or a similar condition associated with a difficult pregnancy but not classifiable as a distinct complication.

Birthing Centers

Coverage for normal pregnancy is payable at 100% for less than a 24-hour stay beginning at the birth of the child. The plan year deductible will be waived.

Exclusions

The Benefit for Complications of Pregnancy does not cover expenses due to direct complications of pregnancy in connection with a pregnancy commencing before a dependent became covered.

These benefits are also subject to the "Exclusions" section with respect to the health care coverages.

Eyecare / Vision Care Benefits
(Self-Referral for Routine Vision Care)

Overview

This Vision Care Plan is designed to help you pay for your eyecare expenses when the services or supplies are performed or prescribed by an Ophthalmologist, Dispensing Ophthalmologist, Optometrist or Dispensing Optician. Benefits will be paid if the service is rendered or the supplies are ordered while covered under the plan.

"Participating Provider" means an Ophthalmologist or Dispensing Optician who has agreed to participate in the pre-paid Vision Care plan for employees and dependents provided by Great-West Healthcare and administered by Medical Eye Services.

"Prescription change" means a new prescription must differ from the prior prescription:

- By at least a 20 degree axis change or at least .50 diopter sphere or cylinder change, and
- Improve visual acuity by at least one line on the standard eye chart.

A list of MES providers is available upon request from your Departmental Payroll/Personnel Assistant.

Covered Vision Care Services and Supplies

The following items are covered under the vision care benefit:

- One complete visual exam in each 24-month period. A follow-up exam at a 12-month interval will also be covered if it is considered necessary by your eyecare specialist. However, there must be a complete 12-month period between the follow-up exam and the next complete visual exam.
- One pair of eyeglass lenses or contact lenses in each 24-month period unless a second pair of lenses is required at a 12-month interval because of a prescription change. For aniseikonic, photo chromatic, no-line (blended type) bifocal, plastic, coated or over-sized lenses, coverage will be limited to the plan allowance for standard glass lenses.
- One set of eyeglass frames in each 24-month period. For oversized, designer or other non-standard frame styles, coverage will be limited to the plan allowance for standard frames.

If, during a visual exam, it is determined that further tests or consultations are necessary for the medical or surgical treatment of the eye, these expenses will be covered under the Comprehensive/Major Medical provisions of this plan. An example would be cataract surgery and the Intra-ocular lens implants associated with such surgery.

Plan Benefits

If you or your dependents go to an MES Participating Provider, the examination will be covered in full. Benefits for standard frames, lenses and contact lenses will be payable up to the maximum fee established by MES. This means there may be some out-of-pocket cost to you.

If you or your dependents choose to go to a Non-Participating Provider, covered eyecare expenses will be limited to the allowances outlined below.

Contact your Departmental Payroll/Personnel Assistant for MES claim forms and a list of the MES Participating Providers in your area.

Schedule Of Vision Care Allowances

(When services are provided by a Non-Participating Provider)

Services and Supplies	Maximum Allowable Expense
Ophthalmologic Examination	$67.50
Optometric Examination	57.50
Follow-up Examination	37.50
Spectacle lenses (per pair)	
- single vision (glass or plastic)	45.00
- bifocal (glass)	63.00
- trifocal (glass)	80.00
- aphakic monofocal	120.00
- aphakic multifocal	200.00
- tints rose or pink #1 or #2	included above
Contact lenses	100.00
Special Conditions *	250.00
Frames	40.00

**Special Conditions include anisometropia or keratoconus; or when visual acuity can be improved to the 20/70 level in the better eye with contacts but not with ordinary eyeglasses.*

Services and Supplies Not Paid for by this Vision Care Plan

- Services and supplies required by an employer as a condition of employment
- Services and supplies you or your dependent receives from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group
- Services and supplies you or your dependent receives in connection with special procedures such as orthoptics or vision training; or medical or surgical treatment of the eye
- Tints other than pink or rose #1 or #2
- Artificial eyes; sunglasses; safety glasses, or non-prescription (plano) lens
- Replacement of lost, stolen or broken lenses or frames which were provided under this plan, except at normal intervals
- Subnormal vision aids.

How to File Your Claims

When MES Provider Is Used

Obtain an MES claim form from a Departmental Payroll/Personnel Assistant. Your MES provider will submit a claim on your behalf.

When Non-MES Provider Is Used

Obtain an MES claim form from a Departmental Payroll/Personnel Assistant. All bills and claim forms should be directed to MES.

When Medical Services for Other Than Routine Eye Care Are Used

If a medical condition exists, seek approval from your physician for services and obtain a Great-West Healthcare claim form from a Departmental Payroll/Personnel Assistant. Retired employees should obtain claim forms from the City's Department of Human Resources. All bills related to non-routine eye care should be sent to Great-West Healthcare for payment.

Do not send your routine eye care bills to Great-West Healthcare for payment. Great-West Healthcare and MES will not pay claims filed later than 15 months after the date of service.

Exclusions

No medical benefits will be paid for:

- Any family planning procedure which requires outside intervention such as, but not limited to, artificial insemination or in vitro fertilization.
- Benefits will only be paid in accordance with medical necessity and any applicable guidelines.
- Birth control devices, including sub-cutaneous implants. Depo-Provera and Norplant are not covered when prescribed as a contraceptive or a birth control medication. Depo Provera will be covered, however, to treat medically necessary conditions as prescribed by a physician.
- Blood or blood plasma given strictly as a replacement by or for the patient.
- Claims received in the Great West Life Benefit Payment Office later than 15 months after date of service.
- Custodial care in a nursing home or similar setting.
- Diet pills, including Meridia and Xenical, even when they are prescribed by a physician or a diet center.
- Elective abortions.
- Expenses applied toward satisfaction of the plan year deductible or copayment previously described.
- Expenses in connection with cosmetic surgery unless due to an accident occurring while covered.
- Expenses or charges related to a sex change.
- Eye refractions are not covered for the purpose of medical treatment of the eyes (See the "Vision Care" section for covered eye care services and supplies.)
- Expenses relating to the treatment of obesity including, but not limited to, gastric bypass surgery and all other related surgeries or treatments ***(and any or all complications arising therefrom)*** or any other treatment programs primarily for dieting or exercise for weight loss, including nutritional supplements, vitamins, over-the counter appetite suppressants or dietary supplements such as Dexatrim and Slim-Fast.
- Family planning and infertility medications.
- Nursing, speech therapy, physiotherapy or occupational therapy rendered by yourself, spouse, or a child, brother, sister or parent of yourself or spouse.
- Prescriptions not "medically necessary" such as fertility drugs and Retin A, or over-the-counter drugs such as vitamins, or fluoride, etc. Also, impotence dysfunctional drugs if the required steps are not followed.

- Radial keratotomy and other procedures for conditions which can be corrected by eyeglasses or contact lenses.
- Reversal of any sterilization procedure.
- Services or supplies (a) furnished by or for the U.S. Government or any other government unless payment is legally required, or (b) to the extent provided under any government program or law under which the individual is, or could be, covered.
- Services and supplies not medically necessary. To be "medically necessary," a service or supply must be ordered by a doctor and be commonly and customarily recognized throughout the doctor's profession as appropriate in the treatment of the diagnosed sickness or injury. It must neither be educational nor experimental in nature, nor provided primarily for research. Also, the length of a hospital confinement and the hospital's services and supplies will be "medically necessary" only to the extent medically related to the treatment of the condition involved and cannot be associated with, (as determined by the insurance carrier), the patient's scholastic education or vocational training.
- Services or supplies received as a result of an accident related to employment, or sickness covered under workers' compensation or similar law.
- Services or supplies received as a result of an act of war (declared or undeclared) occurring while covered.
- Services or supplies received due to an injury or illness caused by or contributed to by committing or attempting to commit any crime, criminal act, assault or other felonious behavior.
- Smoking cessation programs, including behavior modification or other support programs; physician's office visits for smoking cessation treatment; or smoking cessation medications such as nicotine patches and gum.
- Treatment of metatarsalgia, bunions, corns, calluses, fallen arches, hammer toes, gait analysis, trimming of toenails, etc., except as specified elsewhere in this booklet.
- Treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure. However, this exclusion does not apply to:
  - The benefits for dental treatment described under the "Supplemental Accidental Expenses" section, or
  - Charges for the following dental services received within 12 months after an accident: Treatment by a physician, dentist, or dental surgeon of injuries to natural teeth including replacement of such teeth, and related x-rays. The charges for these services will be included with the Dental Expenses described elsewhere in this booklet.
- Treatment of (TMJ) Temporomandibular Joint Dysfunction Syndrome involving dental treatment such as bridgework, splints, appliances, braces, wires, or night guards.

Please note additional exclusions appearing on previous pages.

Pre-existing Conditions

A pre-existing condition is an illness or injury for which you have received medical treatment during the 90 days prior to your effective date of coverage.

If you or your dependent has a pre-existing condition, no expenses for that condition will be covered until coverage under this plan has been in effect for 6 continuous months.

All health plans will cover pre-existing conditions for employees and dependents changing plans during open enrollment as long as you have had coverage under any City plan for 6 continuous months. If you have been covered under either of the City's HMO plans for less than six months and elect to change to a Great-West plan during the Open Enrollment period, you must complete the six-month waiting period before benefits will be paid. The pre-existing condition limitation will be waived for new participants in the Great-West plans if the member provides proof of qualifying coverage under another employer's medical plan for the six consecutive months prior to the date of coverage under the City's plan.

Pregnancy conditions are subject to the above requirements for employees and dependents where applicable.

Coordination With Other Plans

General Provisions

This Group Plan contains a non-profit provision coordinating it with other plans under which an individual is covered so the total benefits available will not exceed 100% of the allowable expenses.

- An "allowable expense" is any reasonable and medically necessary or scheduled expense covered, at least in part, by one of the plans.
- "Plans" means these types of medical benefits: (a) coverage under governmental program (including Medicare) or provided or required by statute, and (b) group insurance or other coverage for a group of individuals.

When a claim is made, the primary plan pays its benefits without regard to other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed 100% of the allowable expenses. No plan pays more than it would without the coordination provision.

A plan without a coordinating provision is always the primary plan. If all plans have such a provision:

- The plan covering the patient directly, rather than as an employee's dependent is primary and the other plan is secondary;
- In respect of a Dependent Child whose parents are not divorced:
  - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year; but
  - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the other plan will be primary.

- In respect of a Dependent Child whose parents are separated or divorced:
  - First, the plan of the parent with custody of the child;
  - Then, the plan of the spouse of the parent with custody of the child; and
  - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, then the benefits of that plan are determined first.

- This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has actual knowledge.
- The benefits of a plan which covers a person as an employee (or as that employee's dependent) who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If none of the above applies, the plan covering the patient the longest is primary.

If you and your spouse are both City employees (and are both covered by this plan as employees) the plan will coordinate benefits in the same manner as if your spouse was not employed by the City.

TEFRA/DEFRA

This provision applies to you if you are an active employee who has attained age 65. It also applies to your spouse if you are an active employee of any age and your spouse has attained age 65.

Upon attainment of age 65, you or your spouse will continue to be eligible for the benefits provided under this Plan. Benefits will be payable as otherwise provided under this Plan except that such benefits will not be reduced by any Medicare benefits to which you or your spouse is entitled solely on account of age. This means that for the purposes of the Coordination of Benefits (COB) section, the benefits payable under Medicare will be determined after the benefits under this Plan are determined.

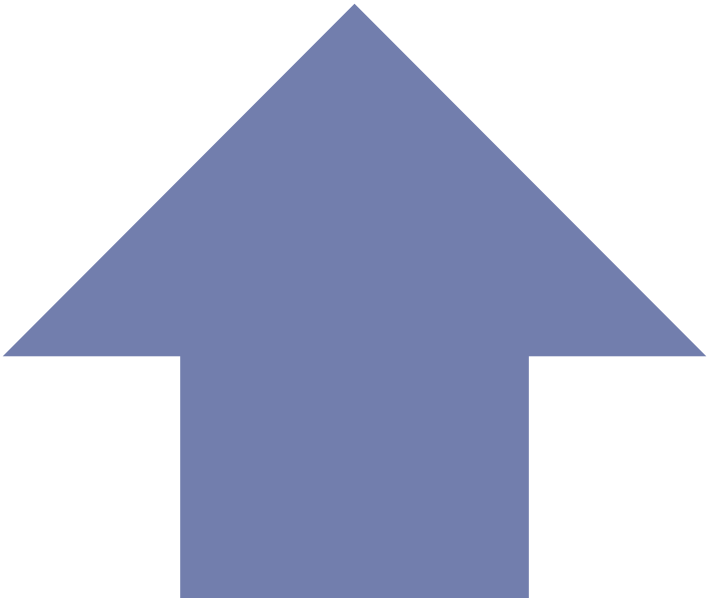
At age 65 you must complete and return TEFRA/DEFRA paperwork to advise the insurance carrier that you choose to remain in the plan as an active employee.

Provision for Covered Persons Who Are Eligible for Medicare on Account of Disability (OBRA)

If you as an active employee or one of your eligible dependents qualify for benefits under Medicare on account of disability, please contact the Department of Human Resources for assistance regarding this provision.

Provision for Covered Persons Eligible for Medicare on Account of End Stage Renal Disease (ESRD)

If you are an active employee and you or one of your eligible dependents qualifies for benefits under Medicare on account of ESRD, please contact the Department of Human Resources for assistance regarding this provision.



Subrogation and Right of Recovery

General Provisions

Another party may be liable or legally responsible for expenses incurred by a covered person for:

- An illness; or
- A sickness; or
- A bodily injury.

"Other Party" is defined to include, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- A workers' compensation insurer;
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under this plan in relation to the illness, sickness or bodily injury. When this happens, Great-West Healthcare may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the other party. The covered person or his or her legal representative will transfer to Great-West Healthcare any rights he or she may have to take legal action arising from the illness, sickness or bodily injury to recover any sums paid under this plan on behalf of the covered person.
- Recover from the covered person or his or her legal representative any benefits paid under this plan from any payment the covered person is entitled to receive from the other party.

The covered person or his or her legal representative must cooperate fully with the insurance carrier in asserting its subrogation and recovery rights. The covered person or his or her legal representative will, upon request from the insurance carrier, provide all information and sign and return all documents necessary to exercise the insurance carrier's rights under this provision.

The insurance carrier will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the covered person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- The amount of benefits paid by the insurance carrier for the illness, sickness or bodily injury plus the amount of all future benefits which may become payable under this plan which result from the illness, sickness or bodily injury. The insurance carrier will have the right to offset or recover such future benefits from the amount received from the other party; or
- The amount recovered from the other party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse the insurance carrier for any benefits which arise from the illness, sickness or bodily injury;
- The covered person or his or her legal representative will be personally liable to the insurance carrier for the amount of the benefits paid under this plan; and
- The insurance carrier may reduce future benefits payable under this plan for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the other party.

The insurance carrier's first lien rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the other party by or on behalf of the deceased employee:

- A minor covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

Continuation of Coverage — COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA') has mandated your right to continue health coverage for yourself and eligible dependents in certain circumstances known as qualifying events.

The qualifying events for continued coverage under COBRA are:

- Your termination for any reason except "gross misconduct"
- Any reduction in work hours to the point where you are no longer eligible for group health coverage
- Your death
- Divorce from the employee spouse
- A dependent child's ceasing to meet the eligibility requirements under the Plan

In the event of your termination of employment (other than for gross misconduct), death, or reduction in work hours, your Departmental Payroll/Personnel Assistant will send notification to your home of all of the necessary information regarding the continuation of coverage.

In the event of divorce, or your dependent ceases to meet the eligibility requirements under the plan, you must contact your Departmental Payroll/Personnel Assistant as soon as possible, but no later than 60 days after the qualifying event date. At that time, you and/or your eligible family members will be given full details about continuing coverage.

If you decide to continue your coverage, you must return the application stating your decision as soon as possible, but no later than 60 days after the date your coverage is scheduled to end. You have an additional 45 days from this date to pay the premiums due. During this time, your coverage will not be effective but will be reinstated when your premiums are paid. The coverage is available at 102% of the full premium cost. The first payment must include premiums retroactive to the date your coverage had ceased. Thereafter, you will be responsible for paying your COBRA premium on a monthly basis.

If your coverage ends due to your termination of employment (other than for gross misconduct) or reduction in work hours, you and your eligible dependents may extend health benefits until the first to occur of the following events:

- 18 months from the date your coverage ends
- The last day of the last period for which the required premium was paid
- The date when the City no longer offers any health or dental coverage
- The date you become insured under another group policy and any pre-existing conditions or limitations of that policy do not apply or are satisfied by you. When your COBRA coverage ends, you will receive certification of the duration of your COBRA coverage.

Your spouse and dependent children also may independently extend their coverage, at their own expense, even if you do not do so. Or, if your spouse's coverage ends due to your death or divorce, he or she may elect to extend coverage. Your spouse's extended coverage ends on the first to occur of the following events:

- 36 months from the date his or her coverage was scheduled to end
- The last day of the last period for which the required premium was paid
- The date when the City no longer offers any health or dental coverage
- The date he or she becomes insured under another group policy and any preexisting conditions or limitations of that policy do not apply or are satisfied by your spouse. When COBRA coverage ends, your spouse will receive certification of the duration of COBRA coverage.

If your dependent child loses coverage due to your death or divorce, or ceases to be a dependent child or eligible student, your child may elect to extend coverage. His or her extended coverage ends on the first to occur of the following events:

- 36 months from the date his or her coverage was scheduled to end
- The last day of the last period for which the required premium was paid
- The date when the City no longer offers any health or dental coverage
- The date he or she becomes insured under another group policy and any preexisting conditions or limitations of that policy do not apply or are satisfied by your dependent child. When COBRA coverage ends, your dependent child will receive certification of the duration of COBRA coverage.

You or one of your covered dependents may be eligible to extend COBRA continuation coverage for an additional 11 months if the following requirements are met:

- Eligible for 18 months of COBRA continuation coverage because he or she experience a loss of health care coverage due to termination of employment or reduction in hours of employment; and

- Qualified for Social Security disability benefits on the date, or any time within the 60 days of the date, he or she first became eligible for COBRA coverage.

To extend coverage for these additional 11 months, notify the COBRA administrator of the Social Security Administration's ("SSA's") determination of disability within 60 days of the qualifying event (if disabled at the time of the qualifying event) or within 60 days of the SSA's determination and before the end of the first 18 months of COBRA coverage. The cost of coverage for months 19 through 29 is 150% of the total premium rate of health care coverage.

If you become entitled to Medicare before plan coverage was lost due to your termination of employment or reduction in hours, your covered dependents may elect continuation coverage for a period which is not longer than 18 months from the termination of employment or reduction in hours.

If a qualifying event occurs during the 18 month period following your termination of employment or reduction in hours, your covered dependents may elect to continue coverage for a period up to 36 months from the date of your termination of employment or reduction in hours.

The continued coverage for any person ends when:

- The cost of the continued coverage is not paid on or before its due date (the first business day of each month for that month's coverage and subject to a 30-day grace)
- The covered person becomes entitled to Medicare
- The covered person becomes covered under another group health plan which does not contain any exclusion or limitation with regard to pre-existing conditions
- The plan terminates for all employees
- The covered person's continuation period is exhausted

Benefits during the continuation period are the same as those for similarly situated active employees. However, unless specifically prohibited by any collective bargaining agreement, the City reserves the right to alter the plan in any way for all its employees and other covered individuals at any time.

Health Coverage Conversion Privilege

General Provisions

If your COBRA coverage terminates, you may convert your COBRA coverage to conversion coverage, provided you have been covered under the group plan for at least 3 months.

The conversion coverage will cover you, your spouse and your dependent children, provided they were covered under the group plan, (but will not cover a person who is eligible for Medicare Benefits solely on account of age).

Your spouse may also convert to conversion coverage in the event of your death, or if your marriage is annulled or ends in divorce.

Your dependent children may also convert to conversion coverage in the event of your death where there is no surviving spouse or if their coverage would otherwise terminate because they no longer qualify as eligible dependents.

The conversion coverage must be applied for within 31 days after the applicant's coverage terminates.

No medical exam is required.

If you elect to convert to conversion coverage, be aware that the conversion plan will not provide the same benefits or cost the same as the group plan. If you are interested in obtaining conversion coverage, call (800) 537-2033 for the description of benefits available and the applicable premiums.

Exception for Persons Whose Coverage Is Being Continued Under COBRA

You and/or your dependents who have elected COBRA will only be able to exercise this Conversion Privilege at the end of the applicable 18, 29, or 36 month maximum period of COBRA continuation. This will be the case unless:

- The plan terminates in its entirety and isn't replaced within 30 days; or
- You or one of your eligible dependents becomes ineligible for disability benefits under the Social Security Act after 18 months but before the expiration of the 29 month extension of the maximum period of COBRA continuation.

Explanation of Benefits

It's easy to find out how your claim has been paid by reading the Explanation of Benefits (EOB) you receive after the claim has been processed (see the illustration for an example). It shows:

1. Service Description

Displays a brief description of the service provided.

2. Dates

The date the patient received services from the provider.

3. Charges

The amount the provider billed for the service.

4. Covered Expenses

This shows the amount of the charges that are allowed under the plan. Also shown is the percentage the plan pays on these charges.

5. Not Covered

Any portion of the charge not covered will be shown here. A note will be placed on the EOB that explains why services were not covered.

6. See Note

Codes in this column indicate more information about this claim can be found in the note section below.

7. Calculation of Benefits

This section displays the total amount of covered expenses along with any copays and deductibles. Once the balance is determined, the percentage of coverage is applied to determine the total benefits payable.

8. C.O.B.

The Coordination of Benefits section displays information regarding payments made on these charges through other insurance coverage.

9. Total Benefits

The total amount of the charges that will be considered for payment.

10. Net Payable

This is the amount of the charges paid under the plan.

11. Patient Owes

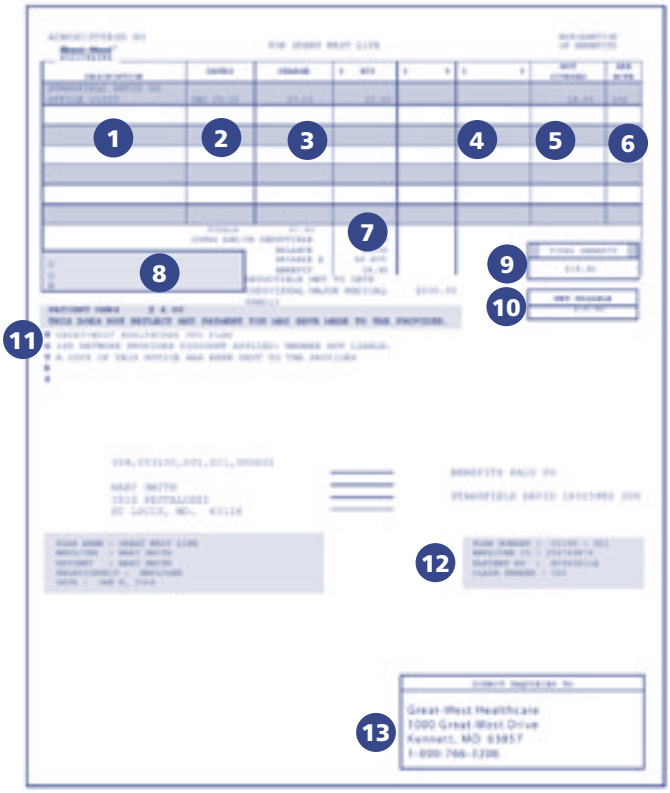
The portion of the charges, if any that are the patient's responsibility.

12. Reference Information

This section displays member, patient and plan information related to the claim.

13. Direct Inquiries To

Information for contacting the carrier regarding this claim can be found here.



Information regarding all of your claims can be accessed by:

Calling the customer service telephone number shown on your ID card and using the Interactive Voice Response option

-or-

Checking the claims information in the members section of the Great-West Healthcare Internet site at www.mygreatwest.com

General Information

Family Care Leave and Americans with Disabilities Act

This plan is in compliance with the California Family Care Leave Act, the Federal Family and Medical Leave Act, and the Americans with Disabilities Act. Contact the Department of Human Resources for additional information.

Claims Information

Notice of Denial of Claim

If any benefits are denied, either in whole or in part, notification of the specific reason or reasons for the denial will be given along with reference to the pertinent plan provisions on which the denial is based. Guidance as to the additional material or information required to perfect the claim will also be given.

Notice of any decision denying the claim must be furnished within 90 days after the claim is filed. If special circumstances require an extension of time to act on the claim, another 90 days will be allowed. If such an extension is required, notification will be given before the end of the initial 90-day period.

If the claim is not processed or a notice is not given within these time periods, the claim will be deemed to have been denied for the purpose of proceeding to the claim review procedure described in this section.

Appeal of a Claim Denial

If there are any questions about a claim payment, Great-West Healthcare should be contacted. If it is desired to initiate a claim review procedure because there is disagreement with the reasons why the claim was denied, Great-West Healthcare should be notified in writing within 60 days after receipt of the written claim denial. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

Decision on Review

Notification of the final decision will be given 60 days after receipt of a request for review unless special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing, in which event a further 60 days will be allowed.

Employer's Right to Change or Terminate the Plan

Notwithstanding any specific bargaining union contract to the contrary, there are no guarantees that participation under the plan for employees or other covered persons will exist or remain unchanged in future years. The City necessarily reserves the right to change, suspend, or amend the plan at any time, in whole or in part. This means that the plan may be discontinued in its entirety, changed to provide for different cost sharing between the City and employees, or changed in any other way. Any such change or termination shall be solely at the discretion of the City. If a change or termination occurs, you will be notified.

Communicating with Your Doctor

Here are points to consider and questions to ask to help open the lines of communication between you and your doctor. Choose the questions that apply to your situation.

Illness - Ask Your Doctor

- What is wrong? (Can you draw/show me a picture of what's wrong?)
- Can you show and explain my x-rays to me?
- How serious is this?
- What caused the problem? (Is it something I did/didn't do?)
- Can I prevent this problem from happening again? How?
- Should I see a specialist about this problem?
- Are tests needed? Which tests?
- How will the results of these tests be helpful to you?
- Are there risks associated with these tests? What risks?
- Is treatment needed? What treatment?
- Are there any treatment side-effects?
- How effective is this treatment for conditions such as mine?
- Are there any alternative treatments? What are the pros and cons of these alternatives?
- If I don't do anything about this problem, what's likely to happen?
- How will this treatment affect me physically, mentally, and emotionally?
- What effect would this treatment have on my other medical problems (e.g., high blood pressure, diabetes)?
- How long will I have to have this treatment?
- Is the treatment painful?
- What is your plan if the treatment doesn't work?
- How much of this will my insurance plan cover? What are your fees?

  (Double check with your insurance provider about extent of coverage.)
- For elective (non-emergency) surgery: "I'd like to/need to get a second opinion; how can I arrange to have a copy of my records sent to a second doctor?"

Surgery - Ask Your Doctor

- Where will the surgical incision be? How long will it be?
- How long will I have to stay in the hospital? When will I be able to return to work?
- How involved can my family be in my care?

Prescription Medicines

Ask Your Doctor

- What is this medicine for? How will it help me?
- What are the side effects of this medicine? If they occur, what should I do?

Which should I report to you?

- Can I increase or decrease the dosage on my own, or should I call you first for advice?
- Will this medicine make me sleepy?
- Are there any other medicines (prescription or non-prescription) that should not be taken while I'm taking this medicine?
- Are there any foods I should avoid while taking this medicine?
- Can I smoke or drink alcoholic beverages while taking this medication?
- Can I stop taking this medicine early if the symptoms disappear?
- How soon should I expect to feel better?
- Are you prescribing tablets, capsules, or a liquid? (Tell the doctor if you have difficulty swallowing large tablets, don't like cherry-liquids, etc.)
- For tablets, is it OK if I crush the tablet and mix it with food?
- Should I call you when the medicine is gone?
- Can you prescribe a generic (instead of a brand name) form of this medicine in this case?

Ask Your Pharmacist

- What time of day should I take this medicine?
- Should I take before meals, with meals, after meals?
- When you say I should take this medicine every (4) hours, does that mean I have to wake up at night to take it?
- Can I take this pill with milk? Water? Orange juice?
- What should I do if I forget one dose? Two doses?
- Remember to ask for a child-resistant or easy-off top; aids for remembering when to take pills.

Index